STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

| IN RE: | REVIEW OF AGGREGATE | ) | |
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| | MEASURABLE COST SAVINGS | ) | |
| | DETERMINED BY DIRIGO | ) | FILING COVER SHEET |
| | HEALTH FOR THE THIRD | ) | |
| | ASSESSMENT YEAR | ) | |

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Respectfully submitted,

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STATE OF MAINE
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BUREAU OF INSURANCE

| IN RE: | REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE THIRD ASSESSMENT YEAR | ) ) ) ) ) | BRIEF OF INTERVENOR MAINE STATE CHAMBER OF COMMERCE |
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DOCKET NO. INS-07-900

Pursuant to the Notice of Hearing dated July 19, 2007, and Orders on Intervention and Procedures dated August 7, 2007, Intervenor Maine State Chamber of Commerce (the "Chamber"), by and through its attorneys, hereby submits its Brief.

## I. PROCEDURAL BACKGROUND.

On June 14, 2007, the DHA Agency ("DHA") Board of Directors ("Board") published a Notice of Pending Proceeding and Hearing ("Notice"). The purpose of the hearing is for the Board to determine "the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." The Notice set the intervention deadline for 3:00 p.m. on June 25 and scheduled the hearing to begin at 9:00 a.m. on July 23, 2007 and to continue on July 24 and 26 if necessary. Notice sections 1 & 3. Subsequently, on June 21, 2007, the Board issued Procedural Order No. 1 (the "Procedural Order"), which set the following deadlines:

| | |
|---|---|
| Application for Intervention | June 25, 2007 at 3:00 p.m. |
| Opposition to Intervention | July 2, 2007 at 12:00 noon |

| | |
|---|---|
| Exchange of Witness Lists and Documents | July 16, 2007 at 3:00 p.m. |
| Expert Witnesses Rule 26 Disclosures | July 16, 2007 at 3:00 p.m. |
| Pre-Filed Testimony and Exhibits | July 19, 2007 at 12:00 noon |
| Pre-Hearing Briefs | July 20, 2007 at 12:00 noon |
| Hearing | July 23, 24 and 16, 2007 at 9:00 a.m. |

Pursuant to the Notice, Procedural Order, and 5 M.R.S.A. §9054(1), the Chamber filed its application to intervene as a matter of right, with full party status along with its Objection to Provisions in Procedural Order No. 1, on June 25, 2007. The Board waited until July 2, 2007 to issue an order ("Board Order") granting the Chamber's application, along with other parties, to intervene.

The Board also granted in part the Motions Objecting to Provisions in the Procedural Order, stating: "DHA Agency shall identify and make available at its office by 3:00 p.m. on July 3, 2007, its estimate of and methodology for calculating aggregate measurable cost savings together with the supporting data and documentation." Board Order at paragraph 3. Although the DHA posted information to its website on July 3 at 3:00 p.m., it failed to fully comply with the Board Order, waiting until the afternoon of July 13 to issue approximately 3,500 pages of documentation that it reviewed or considered in developing its savings methodologies.

A description of the DHA's proposed savings methodologies are contained in a July 3, 2007 report prepared by its consultants, schramm-raleigh Health Strategy ("Schramm"). The DHA adopted each of its consultant's proposals in full, and recommended that the Board adopt $92.7 million of AMCS, consisting of the following savings categories:

A. Hospital Savings Initiatives (CMAD) -- $74.9 million
B. Uninsured/Under-Insured Savings Initiatives -- $14 million
C. Health Care Provider Fee Savings Initiatives -- $7.8 million, and
D. Overlap Initiatives -- ($4 million)

At approximately 4:45 p.m. on Friday July 20, the DHA filed amended pre-filed testimony and exhibits supporting $70.6 million of CMAD savings. Thereafter, the Board held

an adjudicatory hearing on July 23 and 24, 2007 ("Board Hearing"). On July 26, 2007, the Board deliberated at a public meeting and adopted AMCS totaling $78,143,400. The total AMCS, divided into the four savings categories, consisted of:

A. Hospital Savings Initiatives (CMAD) -- $70.6 million
B. Uninsured/Under-Insured Savings Initiatives -- $6,343,400 million
C. Health Care Provider Fee Savings Initiatives -- $5.2 million, and
D. Overlap Initiatives -- ($4 million)

The Board reduced its decision to a written decision ("Decision") on August 3, 2007, and filed the Decision along with the record from the Board Hearing with the Superintendent on August 6, 2007.

## II. APPLICABLE LAW.

The statutory provision governing this proceeding is found at 24-A M.R.S.A. § 6913. It reads, in pertinent part, as follows:

> 1. Determination of cost savings. The following are the procedures for determining cost savings.
>
> > A. After an opportunity for a hearing conducted pursuant to Title 5, chapter 375, subchapter 4, the board shall determine annually not later than August 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.
> >
> > B. Within 30 days of the board's determination pursuant to paragraph A, the board shall file with the superintendent its determination as well as the supporting information for that determination. The filing constitutes a public record.
> >
> > C. Following a public hearing held in accordance with the Maine Administrative Procedure Act and no later than 6 weeks following the receipt of the board's determination, the superintendent shall issue an order approving, in whole or in part, or disapproving the filing made under subparagraph B. … The superintendent shall approve the filing upon a determination that the aggregate measurable cost savings filed by the board are reasonably supported by the evidence in the record.

24-A M.S.R.A. § 6913(1).

By its plain language, this provision requires that any AMCS determined by the Board be "annual," "aggregate," "measurable," and "as a result of" (1) "the operation of Dirigo Health" and (2) "an expansion in MaineCare eligibility occurring after June 30, 2004."

Following the determination of AMCS, the Board must file its determination with the Superintendent. Section 6913(1)(B). The Superintendent is required to review this entire filing, which includes both the Board's "determination" of AMCS and the supporting information. Section 6913(1)(C). Thus, the plain language of the law requires the Superintendent to review all aspects of the Board's determination, both legal and factual.

## ARGUMENTS

### III. HOSPITAL SAVINGS INITIATIVE ("CMAD") IS NOT REASONABLY SUPPORTED BY THE EVIDENCE IN THE RECORD.

The basis for the $70.6 million of CMAD "savings" is the voluntary CMAD limit. **AR 5310; 5386.** This voluntary limit was first proposed in May 2003, enacted by the Legislature in June 2003, and became effective in September 2003. P.L. 2003, c. 469, Section F-1(B)**.** The original voluntary CMAD limit applied for a one year period; however, the Legislature subsequently enacted a new voluntary CMAD limit that applies "to each hospital's fiscal year beginning on or after July 1, 2005 and remain[s] in effect through the end of each hospital's fiscal year beginning on or after July 1, 2007." P.L. 2005, c. 394, Section 4(1).

The DHA CMAD Methodology aggregates State fiscal year adjusted (June 30) Medicare cost report data from all Maine hospitals into a single "virtual" hospital. Next, it uses the aggregate cost report data to calculate the virtual hospital's (1) net total costs ("Costs") and (2) case mix and outpatient adjusted discharges ("CMOPAD" or "Volume"). Costs are then divided

by Volume to determine the virtual hospital's cost per CMAD for a selected historical base period and the fiscal year being measured. Finally, the DHA CMAD Methodology uses the selected historical base period data to project a cost per CMAD for the fiscal year being measured. If the actual cost per CMAD for the measured fiscal year falls below the projected figure, the difference is deemed "savings" related to the voluntary CMAD limit, and multiplied by the total number of virtual hospital CMOPAD.

Using this methodology, the DHA originally proposed $74.9 million of CMAD savings related to state fiscal year 2006 (July 1, 2005 to June 30, 2006). It subsequently reduced this amount to $70.6 million just prior to the hearing. Following the Board Hearing, the Board voted to adopt the CMAD methodology proposed by the DHA's consultant Schramm ("DHA CMAD Methodology"), thereby approving $70.6 million of savings. For the reasons that follow, the Chamber believes that the Dirigo Board's determination is not reasonably supported by the evidence.

### A. The DHA's CMAD Methodology Relies Upon Several False Assumptions.

As explained above, the DHA CMAD methodology uses selected historical cost report data to project future cost growth. Administrative Record ("**AR") 52, ln 9-12.** If the actual cost per CMAD in the measured year falls below the projection, the DHA declares the difference to be "savings" attributable to the Dirigo voluntary CMAD limit.

The DHA CMAD Methodology, and the "savings" it produces, relies upon two key assumptions. The first key assumption is that that future cost growth will always equal projected cost growth in the absence of an intervening factor. Indeed, without accepting this assumption, the projection would have no predictive value for "savings."

The second key assumption upon which the DHA CMAD Methodology rests is that any difference between projected and actual cost per CMAD must be attributable to the Dirigo voluntary CMAD limit. Mr. Schramm, the DHA's consultant, offered no evidence supporting this assumption, but instead concluded that the assumption is reasonable because "…the only adjustment that's of the order of magnitude that we're talking about is the Dirigo Health Reform Act." **AR 54, ln 24 - 55, ln 1.**

Chamber witness Mr. Mercier tested these two key assumptions using the DHA's own historical cost per CMAD data (from the Schramm Report Appendix E), and applying the DHA CMAD Methodology for projecting future costs. **AR 5,780-5,781; 5,748-5,749; 5,751-5,752; 5,839-5,840.** Using a base period of SFY 1999 to 2002 projected to 2003, Mr. Mercier's analysis showed that the DHA CMAD Methodology would produce $71.5 million of "savings" for the period July 1, 2002 to June 30, 2003 -- a period that ended before the voluntary CMAD limitation applied and before the Dirigo legislation became law.

The fact that the DHA's CMAD Methodology produces more "savings" before Dirigo than after is enough to discredit the methodology as a reasonable predictor of Dirigo-related "savings." However, Mr. Mercier's analysis does more. By proving (using the DHA's own numbers and projection method) that the pre-Dirigo 2003 actual costs fell below the historical projection, Mr. Mercier's analysis conclusively disproves the two assumptions that are necessary to support a finding of Dirigo "savings":

First, Mr. Mercier's analysis proves that it is not reasonable to assume that future actual costs will equal historical projections. Without proof that actual costs will equal the projection, the DHA CMAD Methodology maintains no predictive value. Certainly, if pre-Dirigo costs fell

substantially below the projection, the fact that 2006 costs fell below the projection cannot have the meaning that the DHA now suggests.

Second, Mr. Mercier's analysis proves that it is not reasonable to assume that the Dirigo voluntary CMAD limit is the only factor that may contribute to a slower rate of growth in cost per CMAD. Indeed, Mr. Mercier's analysis proves that something other than Dirigo caused the rate of growth in cost per CMAD to slow before the Dirigo law was enacted. Furthermore, Schramm's own data proves that the pre-Dirigo rate of growth from 2002 to 2003 was 3.0%, and that the rate of growth post-Dirigo actually increased from 2003 to 2004 (3.19%), 2004 to 2005 (4.02%) and 2005 to 2006 (4.01%). **AR 5,878.**

Significantly, the DHA has offered no evidence to support its assumption that 2006 actual costs would have equaled projected costs but for the Dirigo voluntary CMAD limit. Moreover, the DHA has offered no evidence to support its assumption that Dirigo is the only explanation for the slower rate of growth in cost per CMAD, or that the cause of the pre-Dirigo showing magically disappeared. On the other hand, its own consultant's figures prove that (1) the DHA CMAD Methodology produces more "savings" before Dirigo was enacted than after; and (2) the slower rate of CMAD growth started in 2003 -- before Dirigo -- and has actually increased slightly under Dirigo. Furthermore, Mr. Schramm suggested during cross-examination that the 2003 "savings" could have been the product of the Maine Health Care Challenge, a cost containment effort by Maine hospitals and businesses that started in 2002 – well before Dirigo was even an idea. **AR 71, ln 24-AR 72, ln 11.** Mr. Schramm even conceded that the $71.5 million would not be Dirigo savings, and that the pre-Dirigo efforts that produced the $71.5 million of slower CMAD growth would carry forward to the present year. **AR 360, ln 25-AR 361, ln 16.**

Mr. Mercier's analysis, utilizing the Schramm Report data and projection methodology, conclusively disproved the two assumptions necessary for a finding of CMAD savings. Because the sole basis for the two disproved assumptions was Mr. Schramm's testimony, and neither Mr. Schramm nor the DHA have offered evidence supporting the assumptions, the Chamber respectfully requests that the Superintendent reject them.

### B. The DHA CMAD Methodology Creates an Illusion of "Savings" by Disregarding the Voluntary Consolidated Operating Margin Limit.

The Dirigo law created two voluntary limits on hospitals. P.L. 2005, c. 394, Section 4. The first asks each hospital to "voluntarily hold its consolidated operating margins to no more than 3%." Id. at Section 4(1)(A). The second asks each hospital to "voluntarily restrain its increase in its expense per casemix-adjusted inpatient and volume-adjusted outpatient discharges to no more than 110% of the forecasted increase in the hospital market basket index for the coming federal fiscal year…" Id. at Section 4(1)(B). Read together, these voluntary limits ask hospitals to reduce the rate of cost growth, but clearly allow the hospitals to benefit from any reductions so long as the hospital's consolidated operating margin does not exceed 3%.

The DHA's CMAD Methodology is unreasonable because it disregards the voluntary COM limit. Although the Dirigo law clearly provides that hospitals will maintain a positive operating margin of up to 3%, the DHA CMAD Methodology would have the virtual hospital pass all reductions in cost growth to private insurers -- even if (as was true for a number of Maine hospitals) the hospital had a negative operating margin. See **AR 5,856-5,876.** Similarly, the DHA would count a reduction in cost growth by a hospital that has historically maintained, and continues to maintain, an operating margin at or below 3%, without evidence that the hospital reduced its charges to stay under the 3% COM limit.

As a result, the DHA CMAD Methodology creates the illusion of "savings" which is simply not supported by the evidence in the record. For example, the record contains hospital-only and consolidated operating margins for all Maine hospitals for 2000 to 2005. **AR 5,856-5,876.** This evidence proves that the virtual hospital maintained an operating margin at or below the 3% the voluntary limit -- even when measured on a hospital only basis (consolidated operating margins are generally lower).[1] Compare **AR 5,856-5,862** with **AR 5,867-5,877.** The evidence in the AR also shows that the HFY hospital-only operating margin for virtual hospital totaled $58.5 million in 2000, and that the SFY adjusted hospital-only operating margin for the virtual hospital was $66.4 million, $49 million, $52.9 million, and $73.6 million for 2001, 2002, 2003 and 2004, respectively. **AR 5,862.** Moreover, the AR shows that the virtual hospital operating margin expressed as a percentage has increased under Dirigo, although the virtual hospital as a whole have stayed at or below the 3.0% limit. **AR 5,862 (hospital only) and 5,876 (consolidated).**

Applying the voluntary COM limit as contemplated by the Dirigo law as a simple reasonableness check, it would be unrealistic to assume that the virtual hospital realized $70.6 million "savings" for SFY 2006, or that it had the ability to pass such "savings" to private insurers. Indeed, the "virtual" hospital consolidated operating margin has steadily risen from 2001 to 2005, but has not exceeded the 3.0% margin. Moreover, the fact that the DHA CMAD Methodology produces a "savings" figure that substantially exceeds the historical hospital-only (as well as the lower consolidated) operating margin for all Maine hospitals for 2000, 2001, 2002, and 2003 -- and nearly exceeds the hospital-only total margin for 2004 -- discredits the reasonableness of the methodology itself.

[1] **AR 5,856-5,874** represent calculations made by Dr. Kane on behalf of the DHA for Dirigo Year One (with the exception of the summaries of this data on **AR 5,862 and AR 5,874**).

In other words, the DHA CMAD Methodology creates the illusion of "savings" by inappropriately disregarding the companion voluntary COM limit. Because the DHA failed to provide evidence that the reduced cost per CMAD growth rate caused the virtual hospital to exceed the 3% COM limit (which the evidence shows that it did not), it is improper for the DHA to claim any CMAD "savings." Put simply, a finding of $70.6 million of savings (on top of the $3.7 million of Hospital PIP savings and $5.2 million of Uninsured / Underinsured savings) would have the effect of nearly wiping out the statewide consolidated operating margin for 2005 (the most recent MHA data), which was already at the permitted 3.0%. **AR 5,876.** This would leave the virtual hospital in a precarious financial situation that was clearly not intended by the Legislature, which allowed hospitals to keep their COM at 3%.

### C. The DHA's Selection of a Base Period of 2000-2004 is Unreasonable -- It was Chosen Because it was the Only Base Period that Resulted in Savings.

As explained above, the DHA CMAD Methodology uses historical cost data to project future costs per CMAD, and claims as "savings" the difference between projection and the actual costs. Mr. Schramm, during cross-examination, conceded that the projection (and the resulting "savings") will materially change depending upon which base period is used. **AR 65, ln 15-AR 68, ln 14.** Mr. Mercier's analyses, using data from the Schramm Report, conclusively proved that the amount of "savings" swings drastically depending upon the base period selected. **AR 5,824-5,846; 5,878.** Accordingly, the DHA CMAD Methodology is unreasonable because it is subject to selectivity of data.

For example, according to the Schramm Report data, cost per CMAD grew at a rate of 3.02% from 2002 to 2003, the year before the Dirigo voluntary CMAD limit was enacted. Because the cost per CMAD rate of growth was 4.01% from 2005 to 2006, use of the 2002 to 2003 growth rate as the projection would result in no savings. **AR 5,878.**

Likewise, a base period of 2000 to 2005 would result in no savings. **AR 5,842.**

Furthermore, a base period of 2000 to 2004, using actual cost per CMAD, would result in $23.9 million of "savings," which was further reduced to $19.6 million of "savings" after the correction of the input errors by schramm-raleigh. **AR 5,824 and 5,343.**

From the available options, the DHA selected the only based period that would produce "savings." Not satisfied with the $19.6 million of "savings," the DHA adjusted the 2004 actual cost per CMAD data, thereby increasing "savings" by $50 million.

Mr. Schramm suggested that the two year gap between the base period (2000 to 2004) and the measured year (2006) was appropriate because the Superintendent deemed such a two year gap reasonable in the Dirigo Year Two proceeding. However, a review of the Superintendent's Decision reveals that the finding of reasonableness for the Dirigo Year Two CMAD savings figure was more dependent upon the fact that the DHA Board reduced the Year Two CMAD savings from $72.7 million to $14.5 million. Indeed, the Superintendent noted numerous specific concerns with the Year Two CMAD Methodology, specifically that it failed to address "potential inflation to the baseline cost growth due to abnormally high costs in 2002, the failure to consider potential Medicaid payment cuts, and the degree to which cost reductions produce some offsetting reduction to payments received via cost-based reimbursement for some parts of government financed care."[2] Superintendent's Year Two Decision and Order, p. 10. In addition, the Superintendent warned that the base period was getting too far from the measuring period, stating that "the further removed the year being measured is from the base period, the more tenuous the connection and the more questionable the assumption that all subsequent changes are related to Dirigo." Id. at 18. With respect to the base period, the Superintendent

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[2] Similarly, on Page 8, the Superintendent states that "the use of the median as a measure of central tendency is sometimes desirable when data contains other values, such as those in 2002."

noted that the one year gap in Dirigo Year One "made sense," while his approval of the two year gap, although deemed reasonable, seemed to be more a product of the DHA Board's $58.2 million dollar reduction to CMAD that sufficiently redressed all of the Superintendent's noted concerns.

The addition of new, more proximate fiscal years to the base period has the effect of moderating the impact of the 2002 cost outlier. Indeed, using actual 2004 cost per CMAD reduces "savings" from $70.6 million to around $19.6 million, and the addition of actual 2005 cost per CMAD results in no "savings" at all. However, the DHA's CMAD Methodology violates the intent of the Superintendent's warning in two ways. First, the DHA improperly increased its "savings" projection by leaving out 2005, the most proximate year. Second, and more importantly, the addition of 2004 to the base period is more illusory than real. The DHA's adjustment of the actual 2004 cost per CMAD effectively neutralizes the moderating effect of adding a new fiscal year to the base period. Indeed, the DHA's $33.7 million adjustment grows to $50 million when applied in the DHA CMAD Methodology.

Because the DHA CMAD Methodology employs the only base period that produces "savings," and because the addition of an "adjusted" 2004 cost per CMAD does not effectively address the Superintendent's concern about proximity and the 2002 cost outlier, the Superintendent must reject the DHA CMAD Methodology as not reasonably supported by the evidence in the record.

### D. The DHA CMAD Methodology is Unreasonable Because it Fails to Consider the Continuing Effect of MaineCare Hospital Payment Cuts.

In the Dirigo Year Two Decision and Order, the Superintendent recognized that MaineCare cuts would adversely affect hospital revenues, and this reduction to revenue would potentially lead hospitals to reduce expenses, thus reducing the growth rate for cost per CMAD.

Decision and Order, p. 10. Although the Superintendent found this criticism to be credible, he noted that "there is no evidence in the record to indicate the degree to which hospitals would respond [to MaineCare cuts] with cost reductions as opposed to price increases." Id. He further held that the Board's decision to reduce CMAD "savings" from $72.7 million to $14.5 million sufficiently redressed "the failure to consider potential Medicaid payment cuts" among other valid criticisms he noted. Id.

Admittedly, the Schramm Report declined to adjust its "savings" projection to quantify the impact of the 2002-2003 MaineCare cuts **(AR 61, ln 14-AR 62, ln 4)**, which occurred (not coincidently) starting in 2002 and 2003, the time frame in which cost growth began to slow. **AR 61, ln 14-AR 62, ln 4.** See **AR 5,887** (2002-2003 MaineCare rate cut) and **AR 5,932** (August 2003 MaineCare rate cut). The Schramm Report explained that such a quantification was unnecessary because "Commissioner Wyke … provided testimony that refutes the intervenors contention that MaineCare implemented sweeping reimbursement reductions as a result of Dirigo." **AR 3,280.**

To be clear: The Chamber does not suggest that the MaineCare payment reductions to hospitals were related to Dirigo (just as the Chamber does not believe that any MaineCare hospital PIP increases or physician fee schedule increases are related to Dirigo). However, just as the Superintendent correctly recognized in his Dirigo Year Two Decision, a reduction to a hospital's net revenue must be made up somehow, either by reducing expenses or increasing charges. Either way, a rate reduction will result in decreased CMAD growth.

If a hospital decreases its expenses, cost per CMAD growth will decline because the reduced expenses will be divided by the same Volume (a rate cut would not result in lower utilization, just lower payments). For example, if a hospital has net total expenses of $1,000,000

and volume of 1,000, its cost per CMAD will be $1,000. If MaineCare reduces outpatient reimbursement to this hospital by $50,000, and the hospital reduces expenses by the same amount, then its cost per CMAD would be $950 ($950,000 / 1000).

Even assuming that a hospital elects to increase charges to make up for the $50,000 of lost MaineCare outpatient reimbursement (by definition an increase to cost-shifting), cost per CMAD will still decline because the same expenses will be divided by <u>higher</u> volume. This is because the so-called outpatient equivalent discharges, which are added to case mix adjusted inpatient discharges to determine CMOPAD, are calculated by dividing total outpatient charges (Medicare Cost Report Worksheet C, Pt. I, col. 7 line 103 less lines 34, 35 and 36) by the ratio of inpatient charges to inpatient discharges (i.e. charge per inpatient discharge). **AR 3,324-3,325.** For example, if the hospital raises outpatient charges by $50,000, and assuming a charge per inpatient discharge of $1,000, the new $50,000 of outpatient charges would create an additional 50 outpatient equivalent discharges. Therefore, the hospital's cost per CMAD would still be $950 ($1,000,000 / 1050).

In reality, however, a hospital would not simply increase charges by the same amount of the MaineCare rate reduction. Due to cost-shifting created by governmental payors paying below cost, charity care and bad debt, as well as commercial insurer discounts off charges, an increase to charges in excess of $50,000 would be required. For example, assume that the above hospital's payor mix is 40% Medicare, 20% Medicaid, 5% bad debt / charity care, and 35% commercial payor with an average discount off charges of 20%.

| Payor | Volume | Rate | Net Revenue |
|---|---|---|---|
| Medicare | 400 patients | 80% of costs | $ 320,000 |
| Medicaid | 200 patients | 75% of costs | $ 150,000 |
| BD/CC | 50 patients | 0% of costs | $ 0 |
| Total Net Revenue | | | $ 480,000 |

As the hospital needs additional net revenue of $520,000 ($1,000,000 - $480,000) from its 350 commercially insured patients to cover its $1,000,000 of expenses, it would have to charge these patients approximately $650,000 (due to the 20% discount). If the hospital was now required to realize an additional $50,000 from the commercial payors ($570,000), it would be required to charge approximately $712,500, an increase of $62,500. This would translate to 62.5 additional outpatient equivalent discharges, for a total of 1,062.5. Thus, a hospital that increases charges in response to a MaineCare rate reduction would have a <u>lower</u> cost per CMAD ($941 -- 1,000,000 / 1062.5), than a hospital that simply cut its expenses by the $50,000 ($950 -- $950,000 / 1000).

According to the DHA's key witness, Mr. Schramm, growth in hospital charges has outpaced growth in hospital costs. **AR 45, ln 11-13.** As explained above, this disproportionate increase would be expected during a time period in which MaineCare has reduced outpatient reimbursement to hospitals from 100% of costs to 77% of costs.

Neither Mr. Schramm, Mr. Greene, nor Ms. Wyke denied the existence of MaineCare outpatient rates effective in August 2003 (during SFY 2004), or that the impact of the rate cuts continues through SFY 2006. In fact, the DHA's own supporting documentation identifies a MaineCare outpatient rate cut from 100% of costs to 77% of cost effective August 2003. **AR 6,730.** This was on top of a MaineCare rate reduction for hospitals effective July 1, 2002, which eliminated the inflation factor (COLA) increase to inpatient MaineCare TEFRA rates. **AR 5,887.** Although Mr. Greene's e-mail suggests that the MaineCare outpatient rate increased to 98% effective April 1, 2004, and then decreased to 90% effective July 1, 2004, these rates are not reflected in the applicable MaineCare rules for hospital reimbursement. **AR 5,886-6,042** (MaineCare Hospital Regulations 2002-2006). This is because the increase from 77% to 98%

(and the later reduction to 90%) were financed through the "match" portion of the so-called hospital tax and match program. **AR 5,783-5,791.** Because the hospitals incurred a new cost associated with the increased outpatient reimbursement from 77% to the higher levels, and because there is a net loss to the hospitals as a result of the tax, the MaineCare outpatient increase beyond the 77% is illusory. Indeed, the hospitals received 100% of outpatient cost prior to August 2003 and 77% thereafter. Although the percentage rate was subsequently increased through the "match," there was a substantial new cost (approximately $50 million a year for SFY 2005 and 2006) associated with this increase; furthermore, even with the increased outpatient rates, there was a net loss to the hospitals with respect to the tax.

As explained above, and as supported by the testimony of Mr. Mercier, there was a significant MaineCare outpatient rate reduction beginning in SFY 2004 that continues today. Whether a hospital elects to decrease its expenses or increase its outpatient charges (or a combination of both) to make up for the lost net revenue, the result is the same -- <u>MaineCare rate reductions will produce slower growth in hospital cost per CMAD</u>. As a result, the DHA CMAD Methodology is unreasonable because it refused to address this important concern -- a concern found credible by the Superintendent -- when developing its "savings" projection. Put simply, it is not coincidental that the slowing of rate of cost growth per CMAD started in SFY 2003 and continued through the current measurement period -- the MaineCare program instituted substantial rate reductions during SFY 2003 and 2004 (the impact of which continues to this day).

**E. Cost Based Reimbursement Carve Out.**

The DHA proposed an adjustment to its CMAD Methodology to address the Superintendent's concern regarding the impact of cost based reimbursement. During cross-

examination, Mr. Schramm explained that the purpose of the adjustment was limited to the SFY 2006 data, and it was an attempt to remove from the virtual hospital "discharges and costs associated" with cost based reimbursement for critical access hospitals ("CAH") and MaineCare outpatient payments. This concept makes sense -- once the virtual hospital model computes the unadjusted cost per CMAD by aggregating total net costs and determining CMOPAD (the only two numbers needed to determine CMAD), the only task left is to identify the (1) total net costs and (2) CMOPAD related to CAHs and non-CAH MaineCare outpatient reimbursement, and then subtract them from the virtual hospital total net costs and CMOPAD. Once removed, cost per CMAD may be recalculated.

The documentation created to identify the costs and discharges associated with CAH and MaineCare outpatient reimbursement was consistent with Mr. Schramm's testimony. **AR 6,468-6,477.** For example, the DHA's consultants went to great lengths to carefully document the total Medicare charges, costs, and CMOPAD associated with the CAHs. **AR 6,469; 6,471-6,473.** Likewise, the DHA's consultants carefully documented the MaineCare charges, costs, and CMOPAD associated with MaineCare CAH and non-CAH outpatient reimbursement. **AR 6,469-6,470.** In fact, the starting point for the MaineCare CAH discharge figure (CMAD of $4,515) was the virtual hospital "CAH isolated" data. **AR 6,469-6,470; 6,476-6,477.** This "CAH isolated" figure was used to determine inpatient discharges of 3,726 (4,515 x cost to charge ratio ("CCR") (1.995 rounded) = 9,009; $33,572,407 / 9,009 = 3,726), which was then reduced to 3,454 using the CAH system case mix index ("CMI") of 0.927. **AR 6,469-6,470; 6,472; 6,476-6,477.** The same "CAH isolated" CMAD formed the basis for outpatient equivalent discharges of 8,712 (4,515 x CCR (1.995 rounded) = 9,009; $78,487,256 / 9,009 = 8,712). **AR 6,469-6,470; 6,476-6,477.** The outpatient equivalent discharges (8,712), when

added to the total case mix adjusted discharges (3,454), equals the Medicaid CAH CMOPAD of 12,166 identified on Schramm Report Appendix E. **AR 6,469.**

The separate calculations for Medicare CAH were likewise derived from CAH specific figures. Inpatient and outpatient cost and charges, as well as inpatient discharge data, were accumulated from Medicare cost report data. **AR 6,469; 6,471-6,473.** This information supports a charge per inpatient discharge of $5,205.38 ($45,172,307 / 8,678 = 5,205). This figure, when divided into outpatient charges, supports 26,384 outpatient equivalent discharges ($137,338,653 / 5205.38 = 26,384). This figure, when added to the total case mix adjusted discharges (8,045), equals the Medicaid CAH CMOPAD of 34,429 identified on Schramm Report Appendix E. **AR 6,469.**

Similarly, the starting point for the MaineCare non-CAH outpatient reimbursement analysis was a CMAD of $6,540, which represents the virtual hospital data with "CAHs removed." **AR 6,469-6,470; 6,476-6,477.** This "CAH removed" figure is used to determine the inpatient charge per discharge figure of $14,221 ($6,540 x CCR (2.174 rounded) = $14,221). Because the "CAH removed" value for outpatient charges and inpatient charge per discharge has been identified, we know that there are 16,556 outpatient equivalent discharges associated with MaineCare outpatient cost based reimbursement ($235,443,614 / $14,221 = 16,556).

Interestingly, the CMOPAD for Medicare (34,429) and Medicaid (12,166) were clearly removed from the total CMOPAD for SFY 2006. Although the DHA's own supporting documentation proves that 16,556 outpatient equivalent discharges are associated with the removed MaineCare outpatient cost, and it is undisputed that outpatient equivalent discharges are added to case mix adjusted discharges to determine CMOPAD, Schramm Report Appendix E does not identify and remove these discharges. **AR 6,469.**

As explained in the live testimony of Mr. Mercier, it is clear that the cost based reimbursement adjustment to the DHA CMAD Methodology neglected to remove the outpatient equivalent discharges associated with MaineCare outpatient reimbursement. **AR 208-213.** In fact, one simply has to sum the discharge totals to prove that the DHA CMAD Methodology removes the costs, but not the associated discharges, thus inappropriately increasing cost per CMAD. **AR 6,469.** Furthermore, Mr. Mercier, a recognized Medicare / Medicaid cost report and reimbursement expert, agreed with Mr. Schramm's testimony that the purpose of the cost based reimbursement carve out should be to remove from the virtual hospital the costs and discharges associated with cost based reimbursement. **AR 208, ln 4-11.** This is because any decrease in expenses would naturally flow to Medicare or Medicaid through the mechanisms of cost-based reimbursement. **AR 208.** Mr. Mercier explained that if one properly removed the costs and discharges associated with cost based reimbursement -- as calculated by the supporting documentation for the Schramm Report -- the cost per CMAD would increase from $6,495 to $6,929. Mr. Mercier further explained that this would result in no savings under the DHA CMAD Methodology. **AR 212.**

Although during rebuttal testimony Mr. Schramm argued that the discharges were properly accounted for by running the data back through the virtual hospital model, this explanation is betrayed by three points. First, Mr. Schramm testified that the purpose was to remove the costs and discharges, a goal confirmed by Schramm-Raleigh's significant efforts to make detailed calculations of the costs and discharges associated with CAH Medicare and Medicaid reimbursement and non-CAH MaineCare outpatient reimbursement. Because the starting point for MaineCare outpatient reimbursement column was the "CAH Isolated" data (the virtual hospital with the CAH data already removed), running the revised data back through the

virtual hospital model was clearly an unnecessary step. Second, as Mr. Mercier testified, and Mr. Schramm conceded, the virtual hospital methodology itself produces inconsistent results for discharges. In this case, the MaineCare outpatient costs were removed, but the discharges undisputedly associated with these costs were added back during the second, unnecessary virtual hospital calculation. Lower cost with the same volume will produce a lower cost per CMAD. Since Schramm-Raleigh had already identified the costs and discharges associated with the cost based reimbursement, these figures simply needed to be subtracted from net total cost and CMOPAD to determine the adjusted CMAD. Finally, those in the hearing room following Mr. Mercier's testimony witnessed the uncomfortable scrambling of an army of Schramm-Raleigh consultants. If they had intended this from the outset, they certainly would not have panicked -- and they certainly would not have gone to such great lengths to make detailed calculations based upon "CAH isolated" and "CAH removed" data.

Because the cost based reimbursement carve out from DHA CMAD Methodology plainly removed the costs, but not the discharges, associated with MaineCare outpatient reimbursement, the DHA Board's decision adopting $70.6 million of CMAD "savings" is not reasonably supported by the evidence. Properly applying this carve out would result in no CMAD savings.

**F. CMAD Summary.**

The DHA CMAD methodology should be rejected as unreasonable because (1) it relies upon two necessary assumptions that have been proven false using the DHA's consultant's own data and testimony; (2) recent and historical statewide operating margins do not support the existence of $70.6 million of "savings; (3) the "savings" swings wildly depending upon the projection period used, and the DHA selected (and adjusted) the only period that produced "savings;" (4) the methodology fails to take into account the effect of MaineCare payment

reductions which will produce the illusion of slowing CMAD cost growth; and (5) the cost based reimbursement carve out unnecessarily applied the virtual hospital calculation a second time, which caused documented discharge to disappear and "savings to increase by over $70 million.

For these reasons, the Chamber respectfully request that the Superintendent find that $0 of CMAD "savings" is reasonably supported by the evidence in the record.

## IV. UNINSURED/UNDERINSURED INITIATIVES ARE NOT REASONABLY SUPPORTED BY THE EVIDENCE IN THE RECORD

Pursuant to the Dirigo legislation, the DHA is directed to measure savings related to any reduction or avoidance of bad debt and charity care costs ("BD/CC") to health care providers as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. 24-A M.R.S.A. § 6913(1). In Year 2, DHA (Mercer) determined that there was approximately $6.7 million in savings related to reductions in bad debt and charity care costs. The Superintendent found that many of the assumptions relied on in arriving at this figure were not reasonably supported, and reduced the purported savings to $5.5 million.

Since Year 2, the Governor created a Blue Ribbon Commission ("BRC") to make recommendations with respect to long-term funding for Dirigo Health. Among other things, the BRC recommended convening a working group ("BD/CC WG") to determine the methodology for calculating savings related to any reduction or avoidance of BD/CC. After a series of meetings of the BD/CC WG, a Draft Report dated April 20, 2007, was prepared by DHA and Schramm. Despite the representations in the Draft Report and the Year 3 AMCS Report, there was little consensus among the BD/CC WG members, and members never were provided a final report incorporating the concerns that were expressed. **AR 6,449; 6,453.** DHA and Schramm

nevertheless adopted a methodology almost entirely consistent with the views of the DHA members of the BD/CC WG.

For Year 3, DHA and Schramm purport to measure what they have termed "new money to the system" by reference to claims paid. Pursuant to this methodology, DHA and Schramm asserted that there was approximately $14 million in savings relating to the uninsured and underinsured initiatives; over two times the amount claimed last year and nearly three times the $5 million figure discussed by the BRC.

At the hearing before the Board, the Chamber and other intervenors expressed a number of concerns regarding this new methodology, including:

(1) That as a matter of law the methodology is inconsistent with the plain language of the Dirigo statute;

(2) That DHA and Schramm made no attempt to use actual hospital bad debt and charity care data;

(3) That DHA and Schramm used selected data for their calculations, resulting in artificially inflated "savings";

(4) That the methodology included pharmacy claims, which do not otherwise result in bad debt and charity care costs;

(5) That the definition of uninsured was overly-broad and would include a person who was in fact insured at the time of enrollment in Dirigo, but may have been uninsured for only one day during the previous twelve (12) months; and

(6) That the methodology failed to account for the costs associated with providing services to new enrollees.

The Board accepted the basic premise of "new dollars to the system" as an approach to measuring savings relating to reductions in bad debt and charity care, but shared the concerns that were raised by the intervenors, and adopted the calculation provided by Maine Association of Health Plan ("MAHP") witness, Mr. Jack P. Burke, principal and consulting actuary with

Milliman. **AR 6,958.** This resulted in an adopted savings amount of $6.3 million. Decision at p. 8.

Though the Board adopted a savings amount substantially less than the amount asserted by DHA, the Chamber believes that the methodology itself is contrary to the plain language of the Dirigo statute and must, therefore, be rejected as a matter of law. Further, even if the "new money to the system" method passes muster under Section 6913 (1)(A), an additional adjustment should be made to Mr. Burke's number to account for the broad definition of uninsured, which includes individuals who were uninsured for very short periods of time (as short as a day).

### A. The Uninsured/Underinsured Savings Initiative Methodology is Inconsistent with the Plain Language of the Dirigo Health Statute

With respect to providing insurance for the uninsured, DHA is directed to determine AMCS including any reduction or avoidance of bad debt and charity care costs to health care providers in this State. See 24-A M.R.S.A. § 6913(1)(A) (emphasis added). Despite the ready availability of data from reliable (governmental) sources to measure what actually happened to BD/CC costs, DHA methodology ignores this information and does not seek to determine whether uncompensated care costs were reduced **(AR 406, ln 17-23)**, and Mr. Burke's calculation, though an improvement, is nevertheless based on "new money to the system," not actual BD/CC data. Put simply, in spite of the clear statutory directive, the methodology for measuring any savings relating to the so-called uninsured/underinsured initiatives does not measure reductions in BD/CC to health care providers. Rather, this methodology even as revised by Mr. Bruke attempts to measure "new dollars to the system," using paid claims as the measure.

This is inconsistent with the plain language of 24-A M.R.S.A. § 6913(1)(A) and, therefore, must be rejected.[3]

### B. The Definition of Uninsured and Underinsured is Unreasonable and Chosen Solely to Inflate Purported Savings

The definition of uninsured adopted by DHA counts anyone who was uninsured at any point within the year prior to enrolling in DirigoChoice or MaineCare. Thus, even if insured at the time of enrollment, any individual that was uninsured for even one day in the prior year was counted as uninsured. This definition is unreasonably overbroad. The definition of uninsured should recognize that individual circumstances change and there may be short periods of time when an individual has no insurance during such change in circumstances that have nothing to do with the ability to obtain insurance (employment change, marriage, divorce etc). The Chamber believes that the definition should include a “go-bare” period to reasonably account for such changes in individual circumstances that have no relationship to the ability to obtain insurance. If the definition does not include a “go bare” component, then at the very least, the methodology should include an adjustment to account for the fact that many of the individuals counted as “uninsured” may have been uninsured for a short period of time. Mr. Burke agreed with this point (**AR 473, ln 28-AR 474, ln 15**), but his revised methodology did not include such an adjustment, and the “churn” adjustment by Schramm does not address this point. (**AR 405, ln 21-AR 406, ln 7**) As such, this methodology should be rejected as unreasonable and unsupported, or in the alternative, the Superintendent should make an adjustment similar in concept to the adjustment for “churn”.

[3] Board Exhibit 1 was submitted by the Chamber as per Board instructions – without explanation or narrative, and was submitted in the spirit of compromise totaling approximately $7.4 million. In light of the Board’s adoption of AMCS totaling an incredible $78,143,400, the Chamber submits that the BD/CC savings are unsupported because the methodology is invalid, or even accepting the methodology, the BD/CC savings amount should be reduced.

## V. THE HEALTH CARE PROVIDER FEE INITIATIVES.

The Dirigo Board adopted $5.2 million of savings related to the Health Care Provider Fee Initiatives, consisting of $3.7 million of savings related to the time value of money associated with an increase in MaineCare hospital PIP, and $1.5 million of savings related to an increase in the MaineCare physician fee schedule. As explained more fully below, the Chamber argues that the Health Care Provider Fee Initiatives are not reasonably supported by the evidence in the record.

### A. Hospital MaineCare PIP Increases

The DHA proposed $3.7 million of savings related to the time value of money associated with an increase in MaineCare hospital PIP. Mr. Schramm, the DHA's consultant, testified that the methodology for calculating the savings associated with this initiative was exactly the same as in the prior two assessment years. The Dirigo Board adopted the DHA's proposal in full despite undisputed evidence in the record proving that: (1) the PIP increase was not a rate increase representing new revenue to the hospitals; (2) the avoidance of interest expense and/or the realization of investment income associated with the earlier payments of amount already due are netted against one another on the Medicare cost report, thus duplicating the CMAD savings measure; (3) MaineCare hospital PIP amounts increased both prior to and after Dirigo Health; and (4) the PIP increase realized by the hospitals for SFY 2007 represented the "match" associated with the hospitals tax.

#### 1. The MaineCare Hospital PIP increase does not Represent New Revenue for the Hospitals.

Mr. Greene, the Deputy Commissioner for Operations and Support of the Maine Department of Health and Human Services, the organization responsible for setting MaineCare Hospital PIP amounts, conceded that an increase to PIP does not represent a rate increase to

hospitals. **AR 511, ln 16-20.** The DHA similarly conceded this fact by seeking to claim as savings only the <u>time value</u> (e.g. interest) of the PIP increase, rather than the entire amount of the PIP increase. As the Superintendent has correctly recognized in prior proceedings involving this issue, interim payments represent a cash flow -- not a revenue -- issue for hospitals. <u>See</u> Decision and Order, Docket No. INS-05-700, p. 16 and Docket No. INS-06-900, p. 15-17. Indeed, PIP amounts generally do not affect hospital rate setting because the hospitals book as revenue the expected payments based on a payor's existing rates. **AR 521, ln 22-AR 522, ln 3.** However, when a hospital is forced to borrow money to solve the cash flow issue created by MaineCare's artificially low PIP rates and MaineCare's unnecessary delay in issuing the year-end settlements, this additional interest expense could require a hospital to increase its charges to cover the interest expense created by MaineCare's failure to make timely payments. **AR 522, ln 4-11.**

In his Dirigo Year Two Decision and Order, the Superintendent stated that the

> "intervenors' claims that recognizing savings from increased PIP payments double-counts cost savings would be valid if the savings were reflected on the expense side of the ledger rather than on the revenue side... To the extent that they would have borrowed money and the additional PIP funds avoided the need to incur interest expense, it is possible that the avoidance of interest expense has increased CMAD savings, resulting in double counting. However, there is no evidence that hospitals would have borrowed money in the absence of the increased PIP payment. It is quite possible that the increases simply allowed the hospitals to keep other funds invested, increasing investment income. This would not affect CMAD, so there would be no double counting.

Order, p. 17. Furthermore, the Superintendent criticized the future use of the SFY 2005 base period, stating that "future amount calculated from such base periods may not reasonably be supportable in future years." <u>Id</u>. at 18.

### 2. The DHA PIP Methodology is Unreasonable Because it has Again Used SFY 2005 as the Base Period.

It is undisputable that the DHA PIP Methodology applied the same base period (SFY 2005) that the Superintendent criticized in the Superintendent's Dirigo Year Two Decision and Order. In fact, the documentation offered by the DHA to support its PIP "savings" specifically stated the "savings amounts have been calculated for CY 2007, with no updates to the base data." **AR 6,727.** Because the DHA brazenly refused to adjust the base period, the Superintendent must find that the DHA PIP Methodology is not reasonably supported by the evidence in the record.

### 3. The DHA PIP Methodology Double-Counts the CMAD Savings.

Although the Superintendent found that the investment income (as opposed to avoided interest expense) associated with the time value of the PIP increase would not double-count the CMAD savings, the Chamber respectfully submits that this finding is based upon a misunderstanding of interest expense as reported in the Medicare cost report. As set forth in 42 C.F.R. § 413.153(b)(2)(iii), interest expense is reduced by investment income before it is reported on Worksheet C. **AR 6,054-6,055.** Mr. Mercier's testimony confirms the cost reporting mechanics that prove that any investment income realized by a hospital due to the time value of money would necessarily be offset against the interest expense included in the CMAD calculation. **AR 5,762-5,765.** Therefore, the evidence in the record shows that both the revenue and expense side of the ledger for interest expense and investment income is contained in the CMAD calculation. Accordingly, the Superintendent must disallow any "savings" calculated by the DHA PIP Methodology. Furthermore, the Superintendent must reduce SFY CMAD savings, if any, by the half of the CY 2006 Hospital PIP savings included in the Dirigo Year Two AMCS ($3 million), as CY 2006 and SFY 2006 overlap by six months.

#### 4. The DHA PIP Methodology Unreasonably Assumes that Hospital PIP Payments Would Never Increase But For Dirigo.

The key underlying assumption in the DHA PIP Methodology is that Hospital PIP payments would have been forever frozen at SFY 2005 levels but for the Hospital Study Commission Report that was issued in February 2005. However, the evidence in the record shows that Hospital PIP increased each year prior to Dirigo, with the single largest increase occurring from SFY 2003 to SFY 2004 (before the Hospital Study Commission Report was issued). **AR 6,049.** Furthermore, a large portion of the claimed PIP increases for SFY 2005 ($44 million), SFY 2006 ($45.6 million) and SFY 2007 ($47.6 million) represented the "match" portion of the so-called hospital tax and match program. **AR 6,049.** Because the hospitals incurred a tax to obtain these increased payments, and because the amount of the tax exceeded the "match" received, it is unreasonable to characterize the increased PIP payments as "savings."

### B. A Long Overdue Physician MaineCare Fee Schedule Increase Cannot Support a Finding of Savings.

The Chamber respectfully requests that the Superintendent reject the MaineCare Physician Fee Schedule increase as a measure of savings. The Hospital Study Commission recommended the long overdue fee schedule increase because of a concern about preserving access to physicians. If the physicians have to turn over even some of the long overdue fee increase to private insurers, the rationale for the Hospital Study Commission recommendation would be frustrated.

Tellingly, Commissioner Wyke declined to answer on cross-examination whether a direct appropriate to the DHA would be considered "savings." **AR 504.** The answer is clearly no. However, by approving the MaineCare Physician Fee Schedule increase as savings, the Legislature in the future will be free to appropriate MaineCare money knowing that the amount

will really be an indirect appropriation to the DHA. Indeed, the physicians will have to turn the money over to private insurers, who will then be required to pass the same amount to the DHA in the form of a savings offset payment. In other words, the Legislature will be able to do indirectly what it could not accomplish through a direct appropriation. Furthermore, approving the MaineCare fee increase savings will have the effect of the federal Medicaid program subsidizing the DHA. This is necessarily true because the federal government will pay approximately two-thirds of the MaineCare fee increase through federal financial participation. Since this same money will be passed from physicians to insurers to the DHA, approving this "savings" will improperly divert federal Medicaid funds to the DHA.

Dated: August 21, 2007

Respectfully submitted,

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## CERTIFICATE OF SERVICE

I, William H. Stiles, attorney for the Maine State Chamber of Commerce, hereby certify that on this day the foregoing document was served on the following parties via first-class mail and electronic mail:

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